

DRUG DISTRIBUTOR LICENSE VERIFICATION AFFIDAVIT

APPLICANT Complete items 1-8 only, then forward to the licensing agency for the state in which you are located. Check with that agency for verification of fee charges.

1. Name of Establishment to be Licensed _____

2. Address (Street, City, State, Zip Code) _____

3. Corporate Name _____ 4. Telephone Number () _____

5. Type of Operation:	Distributor	Manufacturer	Repackager	Relabeler
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6. Type of Distribution Activities (check all that apply):	Prescription	Controlled Substances	Over-the-Counter
Cosmetics			
Dentifrices			

7. I HEREBY AUTHORIZE THE _____ TO FURNISH TO THE DELAWARE BOARD
(State Licensing Agency)
OF PHARMACY THE INFORMATION REQUESTED BELOW.

8. Signature of Applicant (Corporation, Partnership, Individual Owner)_____Date_____

DO NOT WRITE BELOW THIS LINE - TO BE COMPLETED BY HOME STATE LICENSING AGENCY

License Number_____ Date License Issued_____ Date License Expires_____

Has this license been encumbered in any way?			Yes	No	If yes, what type of encumbrance?	
Revoked	Surrendered	Limited	Suspended	Restricted	Probation	Lapsed

(PLEASE ATTACH CERTIFIED COPIES OF ALL PERTINENT LEGAL DOCUMENTS)

Has the applicant been convicted under any Federal, State, or local laws relating to drug samples, wholesale or retail drug distribution, or distribution of controlled substances? (If yes, please explain) Yes No

Has the applicant furnished any false or fraudulent material in any application made in connection with drug manufacturing or distribution? (If yes, please explain.) Yes No

Does your licensing agency routinely perform inspections at the facility? (If yes, please answer questions A & B below)	Yes	No

A. Has any inspection of the applicant resulted in deficiency ratings? (If yes please explain)	Yes	No
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B. Date of last inspection _____

Has the applicant met all licensing requirements of your State? (If not, please explain)	Yes	No

BOARD SEAL AREA, AFFIX OFFICIAL STATE SEAL OF LICENSING AGENCY BELOW.

Name _____

State

Title

Date _____

Signature _____

*Licensing agency please return this completed affidavit along with the application to the Delaware Board of Pharmacy at the above address.